Adapting Blueprint Model Programs With Integrity

Accommodations vs. Adaptations

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Department of Justice

- **Civil Rights of Institutionalized Persons Act (CRIPA), 1980: provide medical, educational, mental health care**

- **12-18-03: Justice Department files lawsuit at two Mississippi juvenile training schools:**

  "…students were frequently subjected to physical abuse by staff, routinely shoved and hit, "hogtied" with hands and feet bound together behind their backs, as well as "pole-shackled" with hands tied behind a pole and left on public display for hours at a time."

- **4-16-04: "…unconstitutional conditions at two Maryland juvenile justice facilities**

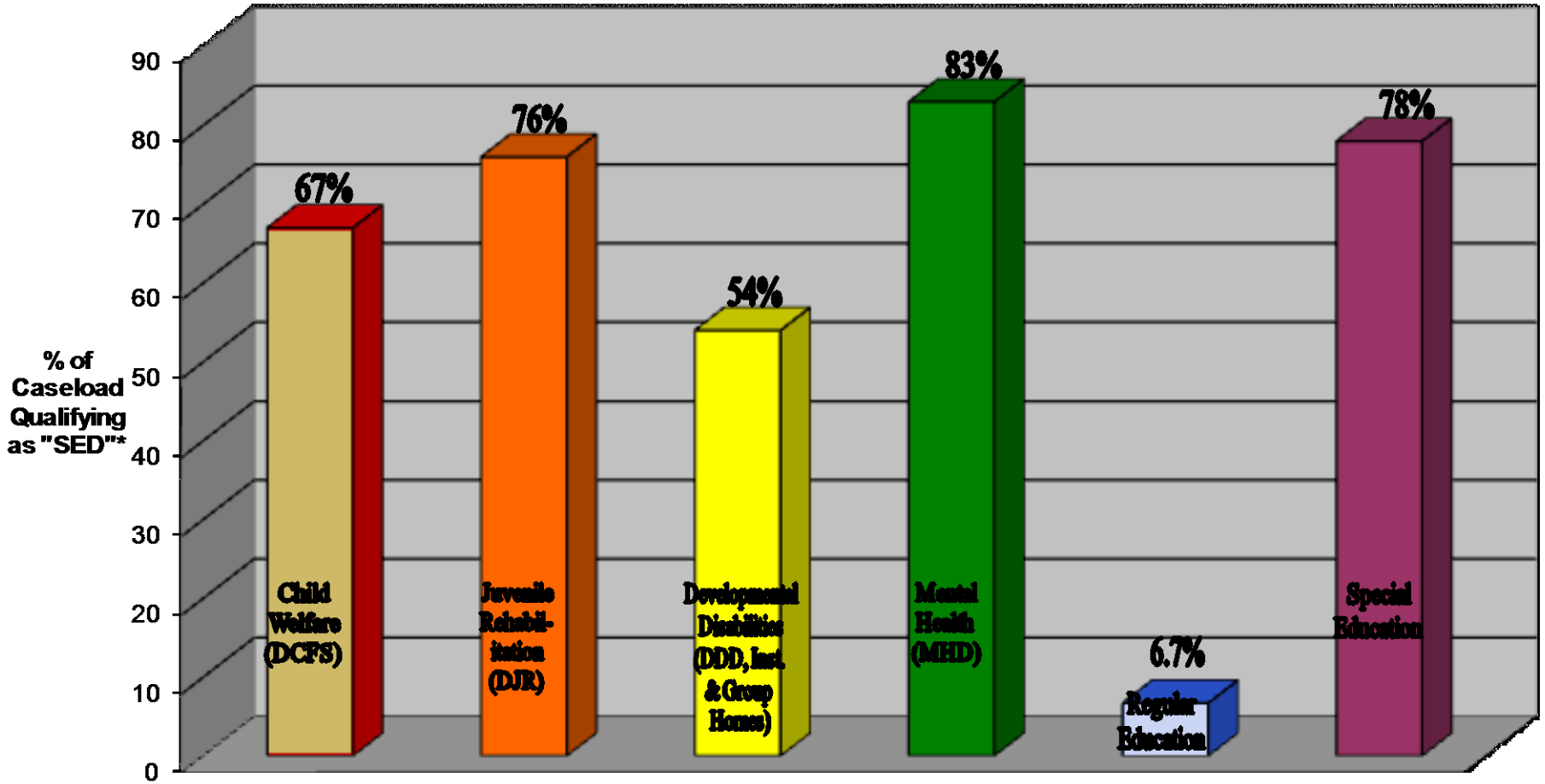
- **"… similar investigations of other juvenile justice facilities in California, Arkansas, Georgia, Louisiana, New Jersey, Puerto Rico... Investigations … are pending in Arizona, Michigan, New Mexico and Indiana."**

Prevalence of Mental Health Disorders

- **21% of U.S. children 9-17 had diagnosable mental or addictive disorders associated with at least minimal impairment**

- **By year 2020, WHO predicts childhood mental health disorders will rise proportionately by 50% internationally, becoming 1of 5 most common causes of morbidity, mortality and disability in children**

Prevalence of Serious Emotional Disturbance (SED) in Washington State



* Percent of Cases "Not different from" the profile of an SED child, based upon five clinical and environmental indices; α = .01

Background

- **There is growing concern over the extent, seriousness and adequacy of response to the mental health needs of youth in the juvenile justice system.**

  1. **Recent research, including a multi-state, multi-system study completed as part of this project, consistently documented high rates of mental disorder**

Background (cont.)

2. **The number of youth with mental health disorders entering the juvenile justice system appears to be increasing**
   - **Texas data show a 27% increase of youth with high mental health needs under a six year period**

3. **Often, youth are being placed into the justice system because of the lack of community-based mental health services**
   - **2/3 of juvenile detention facilities held youth unnecessarily because of unavailable services**

4. **There is little evidence to suggest that youth in the juvenile justice system are routinely provided with adequate or effective mental health services.**
   - **Series of DOJ investigations documenting inadequate clinical services, inappropriate use of medication, etc.**

Areas of Concern in Recent DOJ Investigations

- **Protection from Harm**
- **Suicide Prevention**
- **Inadequate Mental Health & Substance Abuse Services**
- **Inadequate Medical Care**
- **Inadequate Education Instruction of Youth with Disabilities**
- **Inadequate Transition Planning**

Protection from Harm

- **Staff violence**
- **Unsafe restraint practices**
- **Excessive use of disciplinary isolation/lack of procedural protections**
- **Other abusive practices**
  - **Inappropriate staff-youth relationship**
  - **Denial of access to bathrooms**

Inadequate Mental Health & Substance Abuse Services

- **Inadequate screening, identification and assessment**
- **Inadequate clinical assessment, treatment planning and case management**
- **Inadequate psychotropic medication management**
- **Inadequate mental health and substance abuse counseling (i.e., evidence-based practices)**
- **Lack of family involvement**
- **Failure to place youth in court-ordered treatment**
- **Inadequate staff training in behavior management principles**

Suicide Prevention

- **Insufficient assessment of suicidal youth**
- **Inadequate MH services for youth on suicidal precautions**
- **Unsafe housing of youth at risk of self-harm**
- **Inadequate supervision of youth on suicide precautions and in seclusion**
- **Lack of preparedness for suicide attempts and other self-harm**

Inadequate Transition Planning

- **Rehabilitative needs/achievements inadequately communicated to parole counselors, families and community providers**

- **Inadequate transition of youth to community mental health and substance abuse services**

What works with high risk offenders?

CBT Approaches

- **Modeling**
- **Building on & increasing strengths (Skills-focus)**
- **Graduated practice (“Shaping”)**
- **Role Play**
- **Extinction**
- **Concrete Verbal Suggestions (“Coaching”)**
- **Resource Provision**

Family-based community interventions

What doesn't work?

Criminal Sanctions increase likelihood of recidivism

Deterrence (punishment to reduce recidivism) programs increase recidivism.

5 Functions of Treatment

- **Motivation and Engagement of Clients**
- **Skill Acquisition**
- **Skill Generalization**
- **Motivation and Engagement of Treatment Providers**
- **Structuring the Environment**

Transition Planning

The FIT Model

Family Integrated Transitions

FIT is predicated upon the notion that treatment is most effective if all of the factors that sustain a problem behavior are addressed in an *integrated* manner

Transition service planning for juvenile offenders

Integrated transition services, including mental health and substance abuse treatment, financial assistance, and school placement, are rare

Transition planning, post-release mental health services, receipt of financial assistance are associated with lower rate of re-offending at 6 month follow-up

(Trupin, Turner, Stewart, & Wood, 2004)

Successful Transition

Prepare youth for increased responsibility and freedom in the community

Facilitate youth-community involvement

Work with community support systems, like school and family, on qualities needed for constructive interaction with youth.

Monitor and test the youth and support systems on their ability to deal with each other productively.

Beginnings of FIT: A recognized need for transition services

Within 3 years of release from Washington's Juvenile Rehabilitation Administration, 68-78% of youth were convicted of new felonies or misdemeanors

2000: Washington State Legislature initiated pilot rehabilitation program for youth with co-occurring disorders who are transitioning back to the community from JRA

Directed that independent evaluation be carried out by Washington State Institute for Public Policy (WISPP)

Family Integrated Transitions (FIT)

A family and community-based treatment for youth:

- **With co-occurring mental health and substance abuse diagnoses**
- **Being released from secure institutions**

Targeted Impacts

-Lower risk of re-offending

-Connect youth with appropriate community services

-Achieve youth abstinence from drugs/alcohol

-Improve mental health status and stability

-Increase prosocial behavior

-Improve youth's educational level and vocational opportunities

-Strengthen family's ability to support youth

FIT builds on skills hopefully developed while incarcerated, focuses on generalization

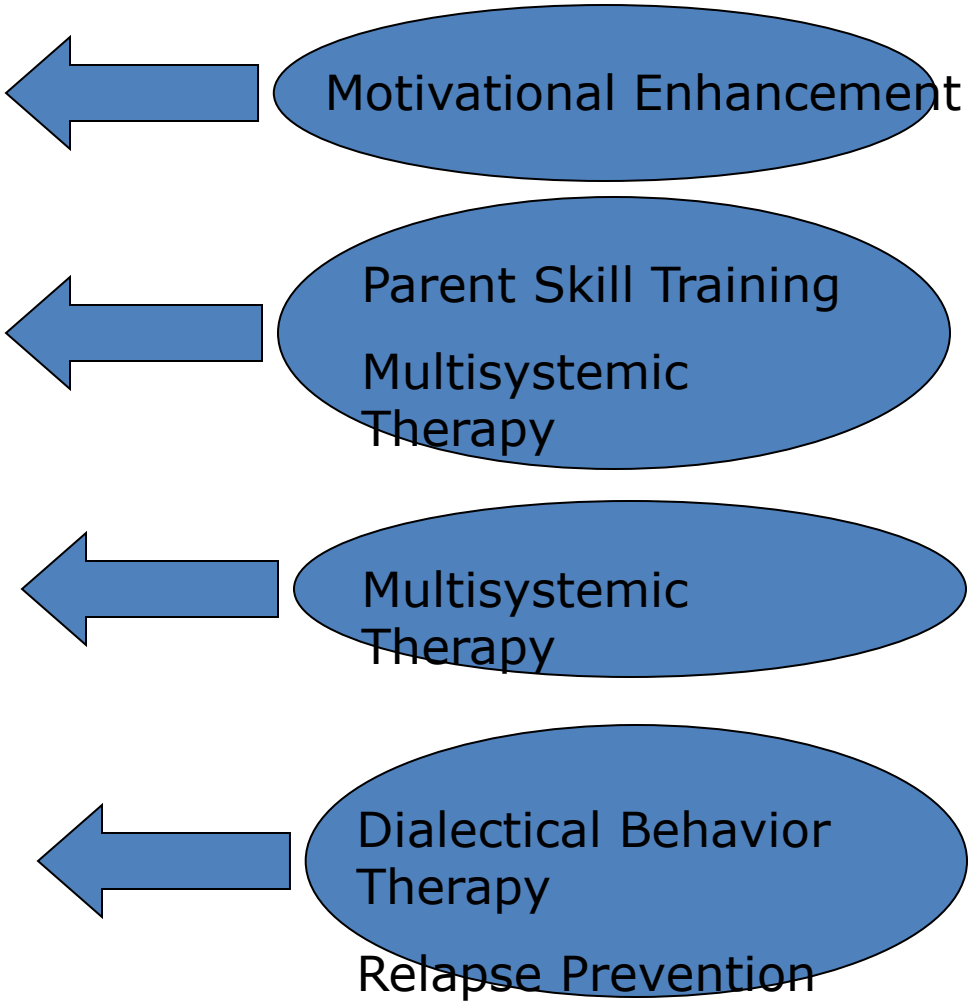
- **Use of evidence based approaches to treatment**
- **Cognitive-behavioral basis**
- **Coping Skill development: DBT**
- **Functional analysis of behavior**
- **Building commitment to change through motivational enhancement**

DBT Skills

- **Core mindfulness**
- **Emotional regulation**
- **Distress tolerance**
- **Interpersonal effectiveness**

FIT addresses the multiple determinants of behavior change

- Engagement factors
  - Commitment to change
  - Participation in therapy
- Family factors
  - Parenting skills
  - Family relationships
- Systemic factors
  - School
  - Community
  - Faith-based organizations
  - Juvenile Justice
- Individual factors
  - Emotion regulation
  - Interpersonal Effectiveness
  - Substance use/abuse
  - Mental Health problems
  - Prosocial behavior



FIT: Target Population
Inclusion Criteria

- **Ages 11 to 17 at intake**
- **Substance abuse or dependence disorder AND**
- **Axis I Disorder OR currently prescribed psychotropic medication OR demonstrated suicidal behavior in past 6 months**
- **At least 2 months left on residential sentence or 6 months on probation or parole**

FIT Teams

- **3-4 therapists per team**
  - **3-5 families per therapist at any given time**
  - **Frequent contact with the family, especially early on, to establish engagement and structure**
- **1 supervisor per team (0.5 FTE)**

FIT: Treatment

- **Begins 2 months before release to allow time to prepare family and systems to support successful transition and lasts approximately 4 months post-release**
- **Therapist meets with family at least once per week**
- **Therapist on call 24/7**
- **Treatment takes place in the community where the youth lives**

FIT Oversight

- **Weekly group supervision with supervisor**
- **Individual supervision as indicated**
- **Weekly telephone consultation with FIT consultants**
- **Availability of psychiatric consultation for team and/or providers**

The FIT Manual

Chapter 1: Overview of FIT, goals of program

Chapter 2: Description of theory and practice of key therapeutic approaches

Chapter 3: Therapist's Toolbox

Chapter 4: Referral and Engagement

Chapter 5: Pre-Release Multisystemic Interventions

Chapter 6: Parent Behavioral Skills Training

Chapter 7: Pre-Release Sessions

Chapter 8: Homecoming

Chapter 9: Maintenance

Chapter 10: DBT skills

Chapter 11: Barriers and Solutions

Therapist's Toolbox

Contains information on a variety of techniques from different intervention approaches that are to be employed throughout the intervention

- **Fit circles**
- **Behavior Chain Analysis**
- **Readiness rulers**
- **Pros and Cons**
- **Goal setting**
- **Interaction techniques**
- **Commitment strategies**
- **Mindfulness exercises**
- **Diary card**
- **Educational handouts**

FIT Benefit-Cost Analysis

-Total cost of FIT per participant: $9,665

-Benefits to taxpayers in criminal justice savings per participant: $19,502

-Benefits to non-participants from avoided criminal victimizations per participant: $30,708

-Total savings per participant =$50,210

-Net gain per participant=$40,545

Effects of Participation in FIT on 36-month Recidivism

Youth in FIT 30% less likely
than youth not in FIT
to have felony recidivism.

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